IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION AT MEMPHIS

MARILYN DONALD and CHARLES DONALD, as next-of-kin and wrongful-death representatives of the late MARCUS DONALD, and in their individual capacities,

Plaintiff(s),

v.

FLOYD BONNER, Jr., KIRK FIELDS; TERRI PARKER s-2168; FILMORE VARNER, s-7792; NATASHA WILLIAMS; T. JOHNSON, s-7875; D. "HOT ROD" ROBERTSON, s-5089; G. SMITH, s-4905; T. BAKER, s-6095; DONTREAL HAWKINS, s-8024; KIMBERLY WALLACE, s-11184; BRENDA McCOY, s-5447; f/n/u GRANDBERRY; and the GOVERNMENT of SHELBY COUNTY, TENNESSEE,

Defendants.

Case No. _____

JURY DEMAND

COMPLAINT UNDER THE CIVIL RIGHTS ACT OF 1870

I.
PRELIMINARY STATEMENT

Shelby County Sheriff Floyd Bonner, Jr. took over the Sheriff's Office (the "SCSO") of Shelby County, Tennessee on January 1, 2019. Since then, forty-four inmates have died in SCSO custody, mainly at the Shelby County Men's Jail (the "Jail") located at 201 Poplar Avenue in Memphis, Tennessee 38103. The Jail's deathrate spiked dramatically in Bonner's first term of office. By the end of 2022, that deathrate hit more than three times the national average for jail-

inmate mortality,[1] outpacing even the per-capita deathrate at Rikers Island Correctional Complex in New York City. Bonner's tenure has also precipitated more inmate-on-inmate assaults in the Jail—quite a few more[2]. Since 2019, the Jail has recorded more incidents of inmate-on-inmate assaults than all Tennessee state prisons combined. *That* is no per-capita comparison. With less than one-ninth the population of Tennessee's fourteen state prisons—including public and private institutions—the Jail has seen more inmate-on-inmate assaults by *raw total*.

Marcus Donald became the thirty-fifth Jail fatality on Bonner's watch after his cellmate strangled him to the point of brain death on November 17 or 18 of that year. He had actually been release-eligible since before noon on November 17, and the Jail should have processed him out of custody hours earlier. Instead, guards locked him in another cell to spend another night.

Marcus Donald's new cellmate, already-accused murderer Stephen Robinson, disliked Marcus Donald. He told guards he would kill Marcus Donald if they put the troubled young man in his cell. After the guards did precisely that, Robinson repeatedly shouted, to other inmates in the cell pod and guards passing by, that he would kill Marcus Donald unless removed from his cell. But no guards or other Jail staff set foot inside the 3rd Floor Echo ("3-E") cell pod for well over an hour, despite desperate efforts by Marcus Donald and other inmates in the pod to summon help.

When Jail guards did re-enter 3-E pod at 12:23 AM, they found Marcus Donald unconscious and not breathing at Robinson's feet. The guards' absence had allowed the

[1] According to the most recent national data. *See* Katherine Burgess, *52 deaths since 2016: Why Shelby County Jail's mortality rates have been rising in recent years*, COMMERCIAL APPEAL (Aug. 16, 2023 5:00 AM) https://www.commercialappeal.com/story/news/local/2023/08/16/52-deaths-since-2016-in-201-poplar-mortality-rates-rose-beginning-in-2020/70013393007/.

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strangulation to occur and Marcus Donald to lie helpless on the floor, without medical care, for some time thereafter. His oxygen-deprived brain never regained consciousness. Marcus Donald went to the hospital and was placed on life support, where he remained for several days before doctors pronounced brain death on November 23, 2022.

This lawsuit is a civil indictment under the laws of the United States against Sheriff Floyd Bonner; Chief Jailer Kirk Fields; Lieutenant Terri Parker; Lieutenant T. Johnson, the other Jail personnel named below, and the Shelby County Government at large for Marcus Donald's brutal, unnecessary death.

II.
JURISDICTION AND VENUE

1. Marcus Donald's natural parents, Marilyn and Charles Donald, bring this action under the United States Civil Rights Act of 1870—42 U.S.C. § 1983 ("Section 1983")—and *Monell v. Department of Social Services of New York City*, 436 U.S. 658 (1978), for violations of their son's rights under the Eight and Fourteenth Amendments to the United States Constitution.

2. This Court holds original subject-matter jurisdiction, under 28 U.S.C. §§ 1331 and 1343(a), to hear and adjudicate Plaintiff's federal claims under 42 U.S.C. § 1983.

3. 28 U.S.C. §§ 1331 and 1343(3), (4), give this Court jurisdiction to adjudicate all state-law claims pendent to the federal claims that are the thrust and gravamen of this action.

4. This Court provides proper venue under 28 U.S.C. § 1391(b) because this action arises from events that occurred in the Western District of Tennessee.

5. Marcus Donald was strangled in his cell on November 17 or 18, 2022. By all accounts, Marylin Donald first learned of his death on November 18, 2022. She then told Charles Donald. Under Tennessee's one-year statute of limitations, the discovery rule as applied to

wrongful-death actions, and because November 18, 2023 falls on a Saturday, Plaintiffs' deadline to file this action is Monday, November 20, 2023. *See* Fed. R. Civ. P. 6(a)(1)(C).

III.
PARTIES TO THE ACTION

6. At all relevant times until his strangulation on or about November 17, 2022, and doctors' subsequent pronouncement of brain death on November 23, 2022, Marcus Donald was a citizen of the United States, the State of Tennessee, and a resident of Shelby County.

7. Marcus Donald is survived by his next of kin, including his parents, Marylin and Charles Donald.

8. Plaintiffs Marilyn and Charles Donald bring this action as Marcus Donald's natural mother and natural father, respectively. Marilyn Donald lives in Tennessee and Charles Donald in California. They are the proper wrongful-death representatives to bring and prosecute this action and do so on behalf of Marcus Donald's estate and all wrongful-death beneficiaries.

9. The following individual Defendants stand subject to service of process at the Jail:

(a) Sheriff Floyd Bonner is sued here in his official capacity as the chief executive and policymaker of Shelby County with respect to the operation and management of the Jail. Statute vests the Shelby County Sheriff with "the charge and custody of" the Jail "and of the prisoners therein." Tenn. Code. Ann § 8-8-201(a)(3). Plaintiffs' official-capacity claims against Bonner are indistinguishable from their claims against the County as an entity and do not represent separate claims. They also sue Bonner for his actions, willful inaction, and (poor) judgment as an individual.

(b) Chief Jailer Kirk Fields is sued here in his official capacity as the head jailer of Shelby County, a claim indistinguishable from that against the County as an entity. Plaintiffs also sue Fields for his actions, willful inaction, and (poor) judgment as an individual.

(c) Lieutenant Terri Parker, s-2168, was at all pertinent times an SCSO employee, a Lieutenant, and a Jail supervisor. Lieutenant Parker was Shift Lieutenant for the Jail's November 17–18, 2022 Charlie Shift (10:00 PM to 6:00 AM). As such, Lieutenant Parker was the ranking SCSO staff member present at the Jail the night in question and held ultimate responsibility for the safety of staff

and inmates. She had to ensure critical posts—including the 3rd Floor Control Room—remained staffed at all times; that security rounds for each cell pod in the Jail occurred at least every fifteen minutes; and the reasonably prompt processing-out of release-eligible inmates. She is sued here in her official and individual capacities. Plaintiffs' official-capacity claims against Parker are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(d) Lieutenant Filmore Varner, s-7792, was at all pertinent times an SCSO employee, a Lieutenant, and a Jail supervisor. Lieutenant Varner served as the Jail's Floor Unit Manager for the November 17–18, 2022 Charlie shift (10:00 PM to 6:00 AM). In that capacity, he held certain responsibility for the safety of staff and inmates. He had to ensure critical posts—including the 3rd Floor Control Room—remained staffed at all times; that security rounds for each cell pod in the Jail occurred at least every fifteen minutes; and the reasonably prompt processing-out of release-eligible inmates. He is sued here in his official and individual capacities. Plaintiffs' official-capacity claims against Varner are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(e) Sergeant Natasha Williams, b/n/u, was at all pertinent times an SCSO employee, a Sergeant, and a supervisor at the Jail. While Plaintiffs aver, on specific information and belief, that no Jail personnel were assigned to the 3rd Floor control room during November 17–18, 2022 Charlie shift, they simultaneously aver (again on specific information and belief), that if anyone were assigned to the 3rd Floor control room during that time, it would have been Sergeant Williams. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against Williams are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(f) Sergeant T. Johnson, s-7857 was at all pertinent times an SCSO employee, a Sergeant, and a supervisor at the Jail. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against Williams are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(g) D. "Hotrod" Robertson, s-5089 was at all pertinent times an SCSO employee and a member of the Jail's Detention Response Team, a violent cabal of aggressive corrections officers known informally as the "Blackshirts." He is sued in his official and individual capacities. Plaintiffs' official-capacity claims against Hotrod are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(h) G. Smith, s-4905, was at all pertinent times an SCSO employee and a Blackshirt. He is sued in his official and individual capacities. Plaintiffs' official-

capacity claims against Smith are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(i) T. Baker, s-6095, was at all pertinent times an SCSO employee and a Blackshirt. He is sued in his official and individual capacities. Plaintiffs' official-capacity claims against Baker are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(j) Deputy Jailer Dontreal Hawkins, s-8024, was at all pertinent times an SCSO employee and a corrections officer at the Jail. During the time in question, Hawkins had been assigned to monitor 3rd Floor pods E, F, and G. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against Hawkins are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(k) Deputy Jailer Kimberly Wallace, s-11184, was at all pertinent times a SCSO employee and a Corrections Officer at the Jail. Plaintiffs aver on information and belief that Chief Fields, Lieutenant Parker, Lieutenant Varner, or one of their designees assigned Wallace to round and monitor several cell pods during the period in question, including 3rd Floor E-Pod. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against Wallace are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(l) Deputy Jailer Brenda McCoy, s-5447, was at all pertinent times a SCSO employee and a Corrections Officer at the Jail. Plaintiffs aver on information and belief that Chief Fields, Lieutenant Parker, Lieutenant Varner, or one of their designees assigned McCoy to round and monitor several cell pods during the period in question, including 3rd Floor E-Pod. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against McCoy are indistinguishable from their claims against the County as an entity and do not represent separate claims.

(m) f/n/u Grandberry was at all pertinent times an SCSO employee of unknown rank and position in the Jail. She is sued in her official and individual capacities. Plaintiffs' official-capacity claims against Wallace are indistinguishable from their claims against the County as an entity and do not represent separate claims.

10. Defendant the Shelby County Government (the "County") is a political subdivision of the State of Tennessee, organized and existing under and by virtue of the laws and the constitution of Tennessee. It stands subject to liability as a "person" under Section 1983 and may

be served with process through its legal department located at 160 North Main Street, Ninth Floor, Memphis, Tennessee, 38103.

IV.
GENERAL ALLEGATIONS

A. *The Death of Marcus Donald*

11. The fourteenth human being to die in custody at the Jail in the 2022 calendar year was Marcus Donald.

12. Marcus Donald entered SCSO custody on May 6, 2022. The deputies who brought him in recommended a mental evaluation. The following day, Marcus Donald's bail was set at $5,000.00.[3] He could not afford that, so he remained in custody at the Jail while his public defender tried to resolve his case.

13. Marcus Donald resolved his criminal case by entering a negotiated guilty plea in Division 9 of the Shelby County General Sessions Criminal Court on the morning of November 17, 2022.[4] The five-month sentence he received made him immediately eligible for release, because he had already spent more than six months in Jail since his arrest.[5] Plaintiffs aver that Judge Sheila Renfroe entered the Order of Judgment no later than 11:30 AM, consistent with her regular practice for accepting guilty pleas.

14. The County should have begun processing Marcus Donald out of the Jail that morning, as soon as the Court's judgment made him eligible for release. Instead, the County

[3] **Exhibit A.**

[4] **Collective Exhibit B**.

continued to hold Marcus Donald in custody at the Jail, as it had done to countless release-eligible inmates before him.

15. As soon as Marcus Donald got back to the Jail from court on November 17, 2022, he started pleading with the guards to take him to "check out"—that is, begin the administrative process for a safe and orderly release from custody. But the guards ignored him, so he stayed locked up.

16. Plaintiffs aver on specific information and belief that the County will blame Division 9 of the General Sessions Criminal Court, the Shelby County General Sessions Court Clerk, or both, for its failure to release Marcus Donald on time. Specifically, Plaintiffs anticipate that Kirk Fields will blame the delay on a failure to receive paper copies of Judge Renfroe's orders entered that day. He will claim his deputies *cannot* release inmates until someone from the court delivers those papers to their physical possession. That will be a lie. The Shelby County General Sessions Court enters orders electronically into the Odyssey computer system in real time. Jail personnel had easy, immediate access to this system in November 2022 and could have readily confirmed Marcus Donald's release eligibility without paper copies of anything. They could also have called the Court Clerk's office or asked one of their fellow SCSO employees stationed in the courtroom what Judge Renfroe had said. Indifferent, they chose not to.

17. At about 5:30 PM, long after Marcus Donald should have checked out, Hotrod and one of the other Blackshirts—either Smith or Baker—came to lead Marcus Donald from his holding cell, purposely as if he were finally checking out. Instead, they led Marcus Donald to 3-E pod, cell number 10 ("3-E-10"), where they told him he would spend the night.

18. Stephen Robinson already lived in 3-E-10. He told the Blackshirts not to put Marcus Donald in his cell. He specifically threatened to kill Marcus Donald if they did. Evidently

indifferent to that prospect, they locked Marcus Donald in the cell with Robinson and walked away.

19. Other inmates in 3-E pod could see partly into cell 10 and hear what those men said.[6]

20. Sometime before 10:00 PM on November 17, Marcus Donald told a staff member—Ms. Grandberry—that he should have checked out hours ago and that he feared for his life locked in the cell with Robinson. Ms. Grandberry—plainly indifferent to either concern, responded, "That ain't got shit to do with me. I ain't coming to work tomorrow no way." With that, she walked out of 3-E.

21. The situation inside cell 3-E-10 went from bad to worse. Robinson, locked up on first-degree murder charges, frequently spoke to other inmates about the crime in a cold, detached way. His pod mates knew him to feel he had nothing to lose, having already "caught a body." He began talking out loud to inmates in other 3-E cells in that same cool, detached manner they knew. But now he was saying he would kill Marcus Donald.

22. Charlie shift began at 10:00 PM. By this time, other inmates in 3-E feared Robinson really would kill Marcus Donald. Not long into the new shift, Sergeant Williams stepped briefly into the pod, pretending to do a security check. Several inmates, including Brandon Watkins, told her that Marcus Donald should have been processed out hours ago and now feared for his safety. As indifferent as Ms. Grandberry, Sergeant Williams walked back out of the pod without assessing the men in 3-E-10 and without so much as a word in response to the other inmates' growing concerns.

[6] These eyewitnesses included inmates DeMario Payne in cell 3-E-20 and Brandon Burchett (a/k/a Brandon Watkins) in 3-E-21.

23. After Sergeant Williams walked out, the inmates in 3-E pod—including Marcus Donald and Robinson, who both wanted Marcus Donald out of that cell—began loudly kicking their cell doors in an effort to summon the guards. This continued for about thirty or forty minutes, so loud and sustained that any Jail personnel anywhere on the 3rd Floor during that time would have heard it. Plaintiffs aver on specific information and belief that Lieutenant Parker, the shift Lieutenant, and Lieutenant Varner, the Floor Unit Manager, assigned no more than two staff members—Officers Hawkins and Wallace—to make security rounds on the 3rd Floor. They further aver on specific information and belief that Sergeant Williams and Officer McCoy had originally been assigned to the 3rd Floor, but either disregarded those assignments or found themselves posted to an adjacent floor by Lieutenant Parker or Lieutenant Varner.

24. Sometime around 10:45 PM, Officer Hawkins made a security round on 3-E. This was her first round of the night; the Jail's nominal policy of conducting security checks every fifteen minutes was a joke. Cell pods on all floors regularly went for hours on end without any security rounds.

25. When Officer Hawkins rounded 3-E pod, Marcus Donald pleaded with her to take him out of the cell because he did not feel safe. Officer Hawkins said she would try to get him moved.

26. Officer Hawkins did try to get Marcus Donald moved. At least she reported the situation to Sergeant Wallace, Sergeant Johnson, and Lieutenant Varner. Indifferent, the supervisors told her to ignore the escalating situation and continue making her rounds.

27. The SCSO Incident Report dated November 18, 2022 (the "Incident Report") implies that, sometime later, Officers Hawkins and Wallace came upon an unresponsive Marcus

Donald in the course of conducting timely security rounds.[7] By that account, as the guards made their security rounds on the Jail's third floor around 12:30 AM, an unknown inmate called them into 3-E to help another inmate.[8]

28. When the guards entered E-Pod, inmates directed them to cell number 10, where they observed Marcus lying on the floor, unresponsive, strangled by Robinson.[9]

29. The recorded video feed from 3-E pod, however, tells a more troubling story.[10] The truth is that no guard set foot inside 3-E for an hour and nineteen minutes, during which time Marcus Donald and Robinson began arguing, then started to fight. Robinson got control of Marcus Donald in the cell and, by his own later admission, grabbed his throat. As other inmates in 3-E tried desperately to summon the guards for help, Robinson, in his own words, slowly "put him to sleep."

30. As Marcus Donald struggled against him in the cell, Robinson said out loud to inmate Brandon Burchett, "Mane I'm finna kill this mane. I'm finna kill this bitch."

31. The 3-E footage also shows that, during the hour and nineteen minutes that no guard or other staff member entered 3rd Floor E-Pod, the E-Pod inmates tried to summon guards for help by waving t-shirts and blankets out of their cell doors in view of the E-pod cameras. Despite some

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[7] *See* **Exhibit C**.

[8] *Id*.

[9] *Id.*

[10] The Jail camera footage is in the Shelby County District Attorney General's ("DA Mulroy") possession. Plaintiffs and counsel were able to view the footage at DA Mulroy's office. Due to Stephen Robinson's ongoing criminal investigation, DA Mulroy has not released the video to the public, but is amenable to filing it with the court, upon entry of an appropriate protective order, or without such an order following the disposition of Robinson's second murder charge.

items striking the camera lens, the efforts went ignored or unseen by guards. The latter case appears more plausible based on the Jail's staffing trends in prior months, as discussed below.[11]

32. In particular, the 3rd Floor E-Pod video feed from November 17–18, 2022 shows the following, beginning at10:56 PM on November 17:

(a) The guard station stands unmanned, consistent with Jail staffing practices under Bonner and Fields, and no guard or other SCSO employee from, at latest, 10:56 PM on;

(b) At 11:04 PM, a guard or other staff member walks down an adjacent corridor, passing the sallyport door at the far end of 3-E pod;

(c) At 11:12 PM, someone in 3-E-22 tries to get the attention of guards by stretching his hand and arm through the cell bars and waiving frantically to the camera and rotating his open palm toward his forearm in a "come here" motion;

(d) At 11:13 PM, someone in cell 3-E-12 (next to the cell holding Marcus Donald and his assailant), waives what appears to be a t-shirt at the camera, clearly trying to summon guards to 3-E pod;

(e) At 11:18 PM, the young man in 3-E-22 tries signaling again, emphatically waiving a t-shirt outside of his cell bars;

(f) At 11:29 PM, the young man in 3-E-22 tries signaling again;

(g) At 12:06 AM on November 18, Demario Payne in cell 21 waives his arm outside the cell bars in another effort to summon guards;

(h) At 12:17 AM, the young man in 3-E-22 tries again to signal, this time waiving a blanket through the cell bars;

(i) After waiving the blanket for about a minute to no avail, the young man in 3-E-22 throws the blanket into the middle of the pod catwalk, resorting to a deliberate disciplinary infraction intended to get the guards to enter 3-E pod, even if just to reprimand him;

[11] Plaintiffs aver on information and belief, strictly in the alternative, that Sergeant Williams was present in the control room, saw the inmates efforts to get her attention, and chose not to respond.

(j) At 12:20 AM, the inmate in cell 3-E-12 throws a piece of paper outside his cell, attempting to summon guards with a disciplinary infraction like the young man in cell 3-E-22 did before him;

(k) At 12:23 AM, one hour and nineteen minutes after any SCSO employee last passed by the sallyport door, Officers Wallace, Hawkins, and McCoy enter 3-E pod;

(l) At 12:24 AM, the guards call code blue (inmate altercation), then code white (medical emergency);

(m) At 12:25 AM, guards put Robinson in handcuffs and walk him out of cell 10;

(n) At 12:27 AM, guards pull Marcus Donald, unconscious, out of cell 10 into the middle of the E-pod catwalk;

(o) At 12:28 AM—a full five minutes after entering third floor E-Pod and finding Marcus Donald unconscious—guards first attempt to render aid;

(p) At 12:42 AM, paramedics arrive and take over the scene.

33. Although SCSO policy mandates Jail staff to "assist, as much as possible, in expediting all required actions to deal with a medical emergency," SOP 838.14(E),[12] Hawkins, Wallace, and other Jail guards who appeared on the scene stood around Marcus Donald's helpless, strangled, unconscious body for five minutes. They made no efforts to expedite anything.

34. An ambulance took Marcus Donald from the Jail to Regional One Health ("Regional One"). He arrived nonresponsive, in cardiac arrest.

35. Intubated upon arrival, Marcus Donald's body began myoclonic jerking—violent, arrhythmic muscle convulsions. Doctors suspected anoxic brain injury.

36. Regional One notified Plaintiffs of their son's admittance to the hospital. Neither Lieutenant Parker, nor any other SCSO employee had bothered to contact them.

[12] **Exhibit D**.

37. Marcus Donald stayed on a ventilator at Regional One for nine days with his mother by his bedside. His half-open eyes stared blankly—sometimes at the floor, sometimes at the ceiling.

38. Marcus Donald remained nonresponsive for several days with occasional episodes of myoclonic jerking. He exhibited no gag reflex and his right eye did not respond to corneal stimulation. Assessment of Marcus Donald's left eye proved impracticable, because stimulating it induced myoclonic episodes.

39. Marcus Donald remained on life support, with no measurable improvement, until doctors conclusively pronounced brain death on November 23, 2022.

B. ***Prior Incidents Attributable to Understaffing and Failure to Supervise.***

40. Marcus Donald's death fit a pattern of inmate deaths attributable to Jail staff failing to conduct cell-pod security rounds every thirty minutes, as SCSO policy (nominally) and the Fourteenth Amendment (actually) require.

41. Guards failed to timely make rounds during each incident described below because the Jail's ineffective staffing policies ensure each post will be understaffed—that is, if the County chooses to assign staff to those posts at all.

42. In the incidents described below, there were no guards assigned to the control rooms, which meant Jail personnel could not supervise the cell pods remotely via live video feed.

43. The staffing records referenced below suggest that, sometime between July 20, 2022 and December 21, 2021, Bonner, Fields, or some other person with final policymaking authority for the County made the deliberate choice to stop staffing the control rooms on the 2nd through 5th floors of the Jail. The records also indicate Bonner and Fields stuck to this policy at least through February 2022.

44. Under this subheading, Plaintiffs discuss two deaths, and one serious brain injury, attributable to poor staffing choices and lack of inmate supervision. Plaintiffs aver on specific information and belief that these instances typify most of the inmate deaths and hundreds of the inmate-on-inmate assaults that have grown so common under Bonner and Fields' tenure.

45. The lack of staff response to the attack on Marcus Donald, despite other inmates' efforts to summon the guards' help through the live camera feed, suggested nothing had changed by November 2022.

(i) Demarcus Jarrett: July 20, 2020

46. On the night of July 20–21, 2020, Jail inmate, Demarcus Jarrett (1-A), bled to death as he sat on the toilet in his cell, suffering from a complication of anticoagulant medication.

47. The Jail's understaffing and sub-standard medical care killed Mr. Jarret. With no guards posted in the cell pods, and no security rounds on 1-AMr. Jarrett bled out in his cell, helpless. The incident occurred during the July 20–21, 2020 Charlie shift (10:00 PM to 6:00 AM). The Jail assigned a single guard, Karen Sayles, to monitor not only Mr. Jarrett's cellpod but another. With no staff member available to relieve her, Officer Sayles missed two thirty-minute security checks in a row, leaving the 1-A completely unattended for an hour and fifteen minutes.

48. According to the Jail's staff summary for the July 20–21, 2020 Charlie shift, *fourteen* Jail staff postings stood vacant that night, with *twenty-one* staff absentees. [13] The Jail recorded *fifty-four* corrections officers and *eight* Sergeants present during that shift.[14]

[13] **Exhibit E**.

[14] *Id.*

49. The 3rd Floor control room sat unattended for the July 20–21, 2020 Charlie shift, according to the Jail's Staff Roster.[15]

50. On March 9, 2022, Fields directed the SCSO's Bureau of Standards and Integrity (the "BPSI") to investigate Mr. Jarrett's death in the Jail, including what factors led and contributed to it.[16] That investigation, and the report that followed on March 10, 2021 put Bonner, Fields, and the County on actual notice of Jarrett's death, the lack of monitoring and supervision inside the cell pods, and the causal role the Jail's chronic understaffing had played in the two.[17]

51. Bonner, Fields, and the County quickly learned of Jarrett's death, the lack of monitoring and supervision inside the cell pods at the time, and the causal role the Jail's chronic understaffing had played in those.

(ii) Coredero Ragland: December 21, 2021

52. On December 21, 2021, Jail inmate Drew Johnson viciously attacked fellow inmate Cordero Ragland (4-P). By his own later admission, Mr. Johnson had used a metal "shank" to chisel a brick-size piece of concrete from his cell wall. For several days, either no Jail guard noticed the new hole in his wall, or none cared. Several days later, he dropped the concrete brick into a pillowcase, then used it to bash in Mr. Ragland's head.

53. Due to the Jail's staffing decisions, no guards or other Jail staff were present in the 4th Floor P-pod at the time Johnson attacked Ragland, nor was anyone monitoring the cell pod via the 4th Floor control room.

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[15] **Exhibit F** at 16.

[16] **Exhibit G** at 1.

[17] *See id.* at 1–5.

54. The attack on Ragland occurred during the December 21, 2021 Alpha shift (6:00 AM–2:00 PM). According to the July 20, 2020 staff summary for that shift, *eighty-five* Jail staff postings stood vacant that night, with *twenty-three* absentees. [18] The Jail recorded *forty-nine* corrections officers and *ten* Sergeants present for Alpha shift that day.[19]

55. According to the December 21–22, 2021 Staff Rosters for Alpha, Baker, and Charlie shifts, the 4th Floor control room—from where someone should have been monitoring 4-P pod via live video feed—was scheduled to be and did in fact sit unmanned for all three shifts. [20] The same was true for the control rooms on the Jail's 2nd, 3rd, and 5th Floors.[21]

56. Plaintiffs aver on information and belief that Bonner, Fields, and the County quickly learned of the attack on Ragland, the lack of monitoring and supervision inside the cell pods at the time, and the causal role the Jail's chronic understaffing had played in the two.

(iii) Antonio Davis: February 26–27, 2022

57. On the evening of February 26, 2022, the Jail found itself again critically understaffed, operating with only about a third as many guards as required to adequately monitor and protect the inmate population. No guards noticed when inmate Antonio Davis (4-J), began showing clear symptoms of amphetamine psychosis, because the shift Lieutenant—Lieutenant Varner, named in this suit—had assigned no one to the 4-J pod that evening, nor any guards to monitor the control rooms.

58. When a Jail staff member, Michael Parker, did enter 4-J pod and encountered Mr. Davis on the edge of a methamphetamine overdose, he could find no one to assist. He found

[18] **Exhibit I**.

[19] *Id.*

[20] *See* **Exhibit J** at 6, 26, 67, 80, 93.

[21] *See id.* at 3, 5, 7, 23, 25, 28, 49–50, 53, 63, 65, 69, 78–79, 81, 91–92, 94.

himself one of only two staff members assigned to monitor the entire 4th Floor, with no sergeant to contact.

59. As a result of the Jail's understaffing that night, Mr. Davis suffered among the Jail's general population, racked by psychosis and tachycardia, instead of getting medical attention. Hours later, following a shift change[22], a different guard discovered Mr. Davis unresponsive in his cell. Rushed to the hospital, he was soon pronounced dead from acute methamphetamine toxicity.

60. Davis' overdose occurred during the February 26–27, 2022 Charlie shift (10:00 PM to 6:00 AM). According to the staff summary for that shift, *sixty-five* Jail staff postings stood vacant that night, with *twenty-six* absentees.[23] The Jail recorded *thirty-one* corrections officers and only *two* Sergeants present for Charlie shift that night.[24]

61. By February 27, 2022, the Jail had done nothing to fill any of the eighty-five vacant Alpha-shift posts recorded two months earlier. The February 27, 2022 staff summary for Alpha shift listed *eighty-five* vacant staff postings, this time with *eighteen* absentees.[25] The Jail recorded *thirty-eight* corrections officers and *three* Sergeants present for Alpha shift that day.[26]

62. According to the Staff Rosters for the February 26–27, 2022 Charlie and Alpha shifts, the 4th Floor control room—from where someone should have been monitoring 4th Floor J-Pod via live video feed—was scheduled to be and did in fact sit unmanned and unattended for

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[22] Upon information and belief, Mr. Davis' overdose occurred during February 26 Charlie shift (10:00 PM to 6:00 AM), but did not receive medical attention until the February 27 Alpha shift (6:00 AM to 2:00 PM). This section contains (under)staffing data from both shifts.

[23] **Exhibit K**.

[24] *Id.*

[25] **Exhibit L**.

[26] *Id.*

all three shifts. [27] The same was true for the control rooms during Charlie and Alpha shifts on the Jail's 2nd, 3rd, and 5th Floors.[28]

63. On March 9, 2022, Fields directed the BPSI to investigate Mr. Davis' death, including what factors in the Jail led to it.[29] That investigation and the May 6, 2022 report that followed put Bonner, Fields and the County on actual notice of Davis' death, the lack of monitoring and supervision inside the cell pods, and the causal role the Jail's chronic understaffing had played.[30]

64. The May 2022 BPSI investigation and the report it produced also put Bonner, Fields, and the County on notice of Lieutenant Varner's attitude of deliberate indifference to the staffing needs of the Jail.

65. Plaintiffs aver on information and belief that Bonner, Fields, and the County quickly learned of Davis' overdose, the lack of monitoring and supervision inside the cell pods at the time, and the causal role the Jail's chronic understaffing had played in the two.

V.
POLICIES AND PRACTICES ALLEGATIONS

A. *A Brief History of Problems at the Jail.*

66. The Jail opened in 1981 as a component of the Shelby County Criminal Justice Center. Problems plagued the facility from the start. These problems worsened during the first eight years of the Jail's operation, taking on constitutional dimension with respect to inmate

[27] *See* **Exhibit M** at 6, 26, 67, 80, 93.

[28] *See id.* at 3, 5, 7, 23, 25, 28, 49–50, 53, 63, 65, 69, 78–79, 81, 91–92, 94.

[29] **Exhibit N** at 1.

[30] *See id.* at 1–9

conditions. These conditions included safety and security concerns due to chronic understaffing and lack of population monitoring and supervision.

67. A class action, *Gilland v. Owens*, 718 F.Supp. 665 (W.D. Tenn. 1989), illuminated many of these issues. *See id.* at 673–89. At trial, the *Gilland* plaintiffs presented Jail records and witness testimony—from both inmates and Jail officials—to prove a pattern of "pervasive" violence in the Jail that posed "a very serious problem" to inmate safety. *Id*. at 673.

68. The *Gilland* plaintiffs' documentary proof showed 685 violent incidents in the first sixth months of 1989, with an average daily population in the Jail of about 2,300 inmates. *Id*. at 687.

69. Testimony from the inmates and guards painted an even more problematic picture. The court found violent incidents happened more frequently than the Jail had reported. *Id*. The court also found "proof that inmates live in fear of personal harm" and that the plaintiffs' evidence made "apparent that every occupant and employee of the [J]ail has constant contact with violence, frequently several times each day or shift." *Id*.

70. *Gilland* held the conditions at the Jail, including understaffing and lack of inmate supervision, saddled the inmate population with an unconstitutional threat of violence. *Id*. at 689. The court instructed the parties to cooperate to improve inmate conditions. For a time, things improved.

71. By the mid-1990s, however, similar problems emerged, including inadequate staffing and supervision of inmates.

72. Another round of litigation prompted the United States Department of Justice to investigate the conditions of confinement at the Jail.

73. In June 2001, the United States issued a report in the form of a findings letter (the "Findings Letter") addressed to the then-mayor of Shelby County.[31]

74. The Findings Letter concluded broadly that "persons confined in the Shelby County Jail risk serious injuries from deficiencies," including in the areas of "security and protection from harm."[32]

75. Specifically, the United States found that Jail inmates faced "an unconstitutional threat of violence from attacks by other inmates."[33].

76. The United States also found that "the Jail is chronically short-staffed and plagued by high turnover and absenteeism."[34]

77. "The ongoing personnel shortage compromises institutional security and the safety of inmates and staff. Due to short staffing, the SCJ routinely requires officers to supervise more than one pod of inmates at a time—notwithstanding that officers have no line of sight supervision of the cells in these pods . . . . Officers do not make required rounds of the catwalks to observe conditions inside the cells . . . [t]hus, housing staff cannot, and do not, supervise inmates adequately."[35]

78. The United States also cited to then-recent litigation, which it described as "replete with examples of inmates who suffered harm at the hands of other inmates without interference from—indeed, often without the knowledge of—correctional officers."[36]

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[31] **Exhibit O**.

[32] *Id.* at 2.

[33] *Id.* at 3 (III.A.1).

[34] *Id.* (III.A.2).

[35] *Id.*

[36] *Id*.

79. "To reduce inmate-on-inmate violence, the County must increase direct sight and sound supervision of inmates in their housing units. If the current configuration of the Jail, in which staff have limited direct sight and sound supervision of inmates, is maintained, then the County must significantly reduce double ceiling, or hire significantly more staff to supervise housing units."[37]

80. As of August 2000—when the Department of Justice notified Shelby County of its intent to investigate the conditions of confinement at the Jail—the County had long been on notice of the depraved conditions in which it houses individuals accused of committing criminal offenses.[38]

81. Particularly, the County has been on notice short staffing and inadequate supervision result in unconstitutional levels of inmate-on-inmate violence.

82. In the wake of the Findings Letter, to avoid protracted litigation and because the County knew it had to change, the County reached a Settlement Agreement with the United States. It detailed certain specific changes the County would make, which the parties agreed were necessary to remedy the Jail's unconstitutional conditions.[39]

83. The County itself proposed many of the remedial measures in that Agreement, including those related to staffing levels, patterns, and postings.

84. The staffing-pattern changes centered on and embraced a direct model of supervision in which the security staff's workstation is located *inside* the inmate housing unit (either inside a pod or a dormitory)."[40]

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[37] *Id.* at 18 (IV.A.1).

[38] *Id.* at 1.

[39] **Exhibit P** at 1.

[40] *Id.* at 3 (III.A.15) (emphasis added).

85. Indeed, the County agreed to "convert *the majority of inmate living spaces* to a direct model of supervision" for the specific purpose of "improv[ing] sight and sound supervision of inmates in their housing units."[41]

86. Conditions at the Jail improved for some time under the direct-supervision model. Indeed, the County budget for years reflected a funding emphasis on maintaining the direct-supervision model. The constitutional rights of inmates remained a County priority through the 2016 Fiscal Year.[42]

87. For the 2017 Fiscal Year, however, something changed. The budget allocation for the Jail that year reflected a reversion to pre-Settlement-Agreement policy norms.[43]

88. For a long time, the County recognized the direct-supervision model as necessary to adequately staff the Jail and supervise the inmates. In the time since it changed funding priorities in 2017, the conditions at the Jail have become more appalling than ever.

B. *Jail Roster Management*

89. No model of clarity, the Jail's Standard Operating Procedures (the "SOPs") speak in terms of "Staffing Patterns," defining these as "post coverage outlined with the number of posts that have to be covered, the number of employees (calculated by the relief factor) that it will require covering each post and the pattern in which the post will be covered."[44] SOP 200.03(X).

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[41] *Id.* (emphasis added).

[42] *See* **Example Q** at L-41–43.

[43] *See* **Example R** at 196–98.

[44] **Example S** at 2.

90. The Jail Administrative Support Office (JASO) is "responsible for the day-to-day operation of the Roster Management system" (the "Roster Management Policy").[45] SOP 200.04(C)(3).

91. Jail staffing policy employs a three-tiered classification system—"[t]he post category system"— to "guide staffing decisions when there are limited employees to fill posts because of vacancies."[46] SOP 200.17 (B).

92. "Each post will be classified"—by Bonner, Fields, or one or both of their respective designees with final policymaking authority with respect to post classification—"as being either fixed, pull, relieved or unrelieved."[47] SOP 200.17(B)

93. A "Fixed Post" means a staff posting "that must be manned" because Bonner and Fields, or their respective designees with final policymaking authority with respect to post classification, have determined that posting critically important "to the operation and safety of the facility, staff and inmates."[48] SOP 200.03(E). Guards assigned to a Fixed Post must report to that post and remain there for the entire shift.

94. A "Pull Post" means "a post which may be left vacant for part of a shift."[49] SOP 200.03(O). Guards assigned to a Pull Post may not be diverted away from that post for an entire shift but may be *pulled* from it for part of a shift and, for a short time, reassigned to another staff posting.

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[45] *Id.*

[46] *Id.* at 8.

[47] *Id.*

[48] *Id*. at 1.

[49] *Id.* at 2.

95. A "Shutdown Post" means "a post which may be left vacant for an entire shift."[50] SOP 200.03 (W). Guards assigned to a Shutdown Post could see that position *shut down* and may be diverted elsewhere for an entire shift.

96. A "Non-Relieved Post" means a "post for which there is no relief factor allocated."[51] SOP 200.03(I).

97. SOP 200.03 does not define a "Relieved Post," but it logically follows that it is a post allocated a relief factor.

98. "Additions, deletions or modifications to the number of approved posts and positions" require Bonner or his designee's approval.[52] SOP 200.04(E).

99. Bonner and Fields' staffing policy does not allow for temporary revision of staffing patterns based on population safety concerns absent certainty "[e]mployees or inmates *will* be injured" otherwise.[53] *See* SOP 200.19(A)(c) (emphasis added).

100. By contrast, the staffing policy does allow for temporary revision based on a mere "*likelihood* of serious property damage" or "imminent danger of" inmate escape.[54] *Id.* at A(b), (d) (emphasis added).

101. The policy for Jail Roster Management provides, "[t]he essential number of staff needed in the institution will be determined individually by post rather than by using gross numbers of staff per shift or any other method."[55] 200.04(B).

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[50] *Id.*

[51] *Id.*

[52] *Id.* at 4.

[53] *Id.* at 10.

[54] *Id.* at 10.

[55] *Id.* at 3.

102. In other words, by determining the necessary number of staff by post, overall staff deficits play no role in the guard-staffing decisions at the Jail.

C. *Fatal Understaffing and Indirect Supervision*

103. Bonner took over as Shelby County Sheriff on January 1, 2019. He dumped the direct-supervision model for staffing. The same problems that plagued the Jail before the County implemented direct supervision returned and grew, by November 2022, to worse than ever.

104. After Bonner took office, he, Fields, or some other person holding final policymaking authority for the County with respect to jail staffing patterns, eliminated guard postings inside the cell pods.

105. This staffing shift kept personnel costs down. It also left entire cell pods unsupervised for extended periods of time. The Jail no longer operated as a direct-supervision facility. The command stations the County had installed inside the cell pods sat empty.

106. Having removed direct supervision, the County nominally adopted certain operational protocols that purported to provide the inmates with constitutionally minimum levels of monitoring and security. On paper, these protocols required guards to make security rounds on each cell pod at least once every fifteen minutes or every thirty minutes—depending on which SCSO representative one speaks to. The new protocols also required the Jail to staff relief officers every shift—available to relieve regular posts as needed—and *constant* monitoring of the cell pods, via live video feed, from control rooms located on each floor of the Jail.

107. By November 2022, those policies existed on paper only. As stated above, the stopped staffing the 2nd through 5th Floor control rooms sometime prior to December 21, 2021. As of that date, the County continued to operate the Jail despite *eighty-five* vacant guard postings.

108. That deficit of eighty-five regular postings left *relief* officers a secondary concern. With the Jail running gossamer crews, guards rarely made timely security rounds and regularly left cell pods unmonitored for hours on end.

109. In 2020, Bonner and County faced a class action in this Court styled *Busby et al. v. Bonner et al.*, No. 2:20-cv-2359-SHL, concerning inmate safety at the Jail during the COVID-19 pandemic. As a component of the resulting consent decree, United States District Judge Sheryl H. Lipman appointed Mike Brady of SABOT CONSULTING, a respected firm specializing in criminal-justice compliance, as a "neutral expert witness in the field of jail and prison operations as it relates to the prevention and mitigation of the spread of infectious diseases and public health in the correctional setting."[56]

110. On March 3, 2021, Mr. Brady reported that while on paper, the Jail had 157 security staff vacancies, according to a staffing study, "the actual need for security staff is over 300 positions."

111. Mr. Brady's fourth and final report (the "Final Report"), dated August 19, 2021, painted a disturbing picture of Jail staffing shortages, a glaring lack of inmate supervision. and the issues the Jail population faced as a result.[57]

112. According to the Final Report, which followed Brady's June 2021 on-site inspection, the Jail's "staffing shortages remain[ed] critically high."[58] He recommended to Chief Fields that the County follow *its own policy* to allow inmates to come out of their cells for exercise.[59]

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[56] **Example T (**Sabot Consulting Report dated August 19, 2021) at 1.

[57] *See id.* at 1,7–8, 26–28, 32–33, 67.

[58] *Id.* at 33.

[59] *Id.* (citing SOP 420.03(A), (B)).

113. It appears those recommendations went ignored. The Final Report stated, "[S]taffing shortages have reached *critical mass* . . . . This problem is reflected in the continuing inability of the [Jail] to provide recreation time and exercise time to inmates in the Housing Pods."[60]

114. Mr. Brady recognized and identified to the County that the Jail's understaffing posed a serious inmate-safety concern in his first inspection, from June 2020. He had reported what he observed: inmates "locked in their cells for 24 hours a day oftentimes for days at a time if not an entire week."[61] He offered his independent, expert opinion that situation "create[d] a serious risk of harm to the mental and physical health" of inmates.[62]

115. The Final Report opined, without qualification or reservation, "It *is not possible* to safely program inmates or to provide recreation time/exercise time to inmates" under the Jail's staffing practices at the time.[63]

116. The Final Report strongly recommended the Jail reduce its inmate population, if it could not increase staff, by utilizing "alternative forms of custody."[64]

117. The staffing patterns discussed under this subheading represent deliberate, affirmative policy choices and deliberate indifference to the lack of inmate supervision in the Jail. On November 17–18, 2022, those choices left the inmates in 3-E pod, including Marcus Donald and Robinson, unattended and without direct supervision. To be fair, that description now applied to all the Jail's cell pods virtually all the time.

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[60] *Id.* (emphasis added).

[61] *Id*. at 26.

[62] *Id.*

[63] *Id.* (emphasis added)

[64] *Id.* at 32.

D. *Death Circles and Deliberate Indifference*

118. Between at least January 1, 2021 and November 1, 2022, Bonner, Fields or their designated representatives attended meetings of the County's Jail Compliance Committee.

119. In addition to Bonner, Fields or their designated representatives, the Jail Compliance Committee includes representatives from the Shelby County Information Technology Services, Shelby County Health Department, and the Jail's private provider of inmate medical care, Wellpath.

120. These monthly compliance meetings address sundry matters related to the Jail and its operation, including inmate safety and security.

121. Although Jail Compliance Committees discusses inmate safety and security at some of its meetings, to date the County has concealed the extent to which these meetings address inmate deathrates, trends, or details specific to any particular inmate death.

122. The Jail Compliance Committee presumably does discuss inmate assaults. Bonner, Fields, and other persons holding final policymaking authority for the County with respect to the Jail had notice in early November 2022 of the disturbing trends in inmate assaults, addressed in more detail below. as a result of the monthly Jail Compliance Committee meetings.

123. During the same time period, Bonner, Fields or some other persons holding final policymaking authority for the County with respect to the Jail also attended secret mortality review meetings (the "Death Circles"), convened and led by Wellpath representatives, to discuss the deaths of inmates in the Jail.

124. As a matter of County policy, when Bonner, Fields, or any other persons holding final policymaking authority for the County with respect to the Jail—or any of these persons'

designated representatives—attend the Death Circles, they agree to take no notes, retain no documents, and keep the substance of all discussions during the Death Circles strictly confidential.

125. It is unclear what the purpose of this confidentiality pact is or why the County prefers to discuss inmate deaths sub rosa.[65]

126. In any event, the clandestine, restrictive terms the County participates in the Death Circles embody and reflect a policy-level decision.

127. Either the Jail Compliance Committee discussed pertinent trends and details of inmate deaths, of the County limited discussion of those topics to the Death Circles.

128. If the Jail Compliance Committee did discuss inmate deaths at its monthly meetings, then Bonner, Fields, and the County knew of the alarming trends in inmate deaths, discussed below, as of November 1, 2022.

129. If discussions of inmate deaths were reserved for the clandestine Death Circles, on the other hand, Bonner, Fields and the County may or may not have been aware of the same trends, depending on which County officials attended which Death Circle. Because the County forbids Death Circle attendees from taking notes, retaining documents, or discussing anything from the Death Circles, the information conveyed at any particular Death Circle would remain in the sole possession of the attendees and could not be shared absent a violation of County policy.

E. *A Refusal to Timely Release*

130. As an unwritten rule for years, the Jail has unreasonably held inmates in custody for extended, unnecessary periods of time after these persons were eligible for release.

[65] Plaintiffs aver, on specific information and belief, that the County imposes these restrictions to shield records of anything discussed at the Death Circles from requests under Tennessee's Public Records Act. *See* Tenn. Code Ann. § 10-7-503.

131. Specifically, since at least 2019, the Jail has demanded inmates legally eligible to be released from custody—due to acquittal, dismissal, or a guilty plea for time served—to instead return to the Jail, then remain there for ten or more hours, after their cases' disposals, waiting to be "processed out."

132. Even inmates who surrender themselves on bench or capias warrants, and are released by the Court without bail, must get booked into the Jail, then processed out—a procedure regularly taking up to thirty-six hours.

133. Nothing legally requires an inmate's return to the Jail for processing after the disposal of his case through acquittal or dismissal, or by entering a negotiated plea for a time-served sentence, like Marcus Donald did on the morning docket on November 17, 2022. The Sheriffs of other counties in Tennessee do not impose post-disposal custody.

134. While not legally necessary, practical administrative considerations might justify some flavor of a mandatory, post-disposal return for processing. But neither Bonner, Fields, or the County, can reasonably defend the Jail's more than ten-hour average holdover time. This is doubly true given that the SCSO represents publicly that, on average, it takes less than two hours to process out an inmate.[66] That representation is a lie.

135. By deliberately emphasizing "[t]he AVERAGE processing time,"[67] the SCSO's website strongly implies that the Jail tracks, aggregates, and analyzes data for process-out times.

136. Unfortunately, the SCSO's holdover policy is so pervasive that lawyers practicing criminal law in Shelby County, and the judges they appear before, simply accept the custom as the Jail's standard way of doing business.

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[66] List and Responses to Inmates' Frequently Asked Questions, SHELBY COUNTY SHERIFF'S OFFICE, https://www.shelby-sheriff.org/inmates-faq (last visited September 14, 2023).

[67] *Id.*

137. The holdover policy is so pervasive and well known that at least one criminal judge, Lee Coffee of Shelby County Criminal Court Division VII, regularly advises defendants in plea colloquies that, even if their pleas make them immediately eligible for release, they should not expect the County to release them for another *ten to fifteen hours*.

138. Surely an *express* refusal by the County to release inmates within a reasonable amount of time following their release eligibility deprives those persons of their liberty without just or probable cause.

139. In the face of the County's persistent, unjustified, and well-known failure to release eligible inmates from the Jail within a reasonable amount of time, the County's refusal to take action amounted to a *constructive* refusal to timely release inmates.

140. The constructive refusal to release inmates from custody within a reasonable time following their release eligibility serves no legitimate administrative or penological objective.

141. Long before November 2022, the Jail's refusal to release inmates within a reasonable amount of time following release eligibility subjected those young men to the substantially increased risk of violence present in the Jail. That substantially increased risk was obvious to anyone.

142. The death or serious injury of a release-eligible inmate was thus a foreseeable result of the custom of unreasonable post-disposal holdovers.

F. *Traumatic Trends*

(i) The Jail

143. Over the next four years, the deathrate inside the Jail more than tripled: it rose from 1.67 deaths per thousand inmates in 2019 to 5.8 deaths per thousand inmates in 2022.[68]

144. According to numbers Bonner and Fields published to Shelby County's local legislative authority, the Board of County Commissioners (the "County Commission"), the number of total assaultive offenses reported in the Jail increased from 595 in 2019, 734 in 2020, 798 in 2021, to 855 in 2022—a forty-four percent increase since Bonner took office.[69]

145. According to the same data, the number of inmate-on-inmate assaults for the calendar years 2019–2022 increased from 505 in 2019, 462 in 2020, 527 in 2021, to 565 in 2022—a twelve percent increase since Bonner took office.[70]

146. During the same period—from the end of 2019 to November 2022—at the direction of Bonner, Fields, or some other person with final policymaking authority for the County with respect to Jail population management, guards significantly increased the percentage time inmates spent locked in their cells at the Jail. COVID-19 protocols contributed to this trend for the years of 2020 and 2021. But even after the pandemic subsided—and continuing through November 2022 and the date of this filing—the Jail maintained a schedule of near-constant inmate lockdown.

147. As the rule rather than the exception, since 2020, the Jail has kept inmates locked down in their calls for days, sometimes weeks on end, denying them recreation because the Jail does not staff enough guards to adequately supervise recreation.

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[68] Burgess, *supra*, https://www.commercialappeal.com/story/news/local/2023/08/16/52-deaths-since-2016-in-201-poplar-mortality-rates-rose-beginning-in-2020/70013393007/.

[69] **Exhibit U**; **Exhibit V**; **Exhibit W.**

[70] **Exs. U, V**, **W**.

148. The increase in the number of Jail assaults during the same time that inmates were spending almost all their time locked down suggested an increase between cellmates or otherwise occurring *inside* the cells (rather than, say, the showers or common areas).

(ii) The Jail versus Rikers Island

149. Under Bonner and Fields' tenure, the Jail has grown more deadly than the notoriously dangerous Rikers Island Jail Complex in New York City. Rikers Island housed 5,559 inmates for the 2021-2022 fiscal year (June-July).[71] The Jail had an average population of 2164 for the same period.[72]

150. In the 2021 calendar year (January-December), the Jail recorded ten inmate deaths.[73] Rikers Island had sixteen.[74]

151. In the 2022 calendar year, the Jail saw fourteen inmate deaths.[75] Two and one-half times the population, Rikers Island saw seventeen.[76]

(iii) The Jail versus the State Prison System.

152. The Tennessee Department of Correction ("TDOC") aggregates records of in-custody incidents, including monthly inmate-on-inmate assaults, by fiscal year for all fourteen

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[71] Shantel Destra, *How many people are detained on Rikers? A look at the crisis by the numbers*, CITY & STATE NEW YORK (Sep. 29, 2022), https://www.cityandstateny.com/policy/2022/09/how-many-people-are-detained-rikers-look-crisis-numbers/377840/.

[72] *See* **Exhibit X**.

[73] Joyce Peterson and Lydian Kennin, *Shelby County Commissioner shares outrage over 201 Poplar conditions*, WMC Action News (Feb. 10, 2023, 10:24 PM), https://www.actionnews5.com/2023/02/11/shelby-county-commissioner-shares-outrage-over-201-poplar-conditions/.

[74] *Id.*

[75] *Id.*

[76] *See* Jan Ransom & Jonah E. Bromwich, *Tracking the Deaths in New York City's Jail System*, N.Y. TIMES (Oct. 19, 2023), https://www.nytimes.com/article/rikers-deaths-jail.html.

correctional institutes across the state.[77] Adding the numbers for the last six months (January to June) of one fiscal year to those for the first six months (July to December) of the next fiscal year yields data by calendar year, comparable to the numbers the SCSO published to the County Commission.

153. In the 2019 calendar year, TDOC saw 505 incidents of inmate-on-inmate assault across Tennessee's fourteen prisons, which had an average daily population of 21,788 inmates.[78]

154. The Jail also reported 505 inmate-on-inmate assaults for the 2019 calendar year,[79] but it saw an average Daily population of only 2,452.[80]

155. In the 2020 calendar year, TDOC saw 426 incidents of inmate-on-inmate assault across Tennessee's fourteen prisons,[81] which had an average daily population of 20,259 inmates.[82]

156. The Jail reported 462 inmate-on-inmate assaults that year,[83] with an average Daily population of 2,022.[84]

157. In the 2021 calendar year, TDOC saw 532 incidents of inmate-on-inmate assault across Tennessee's fourteen prisons, which had an average daily population of 20,091 inmates.[85]

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[77] **Exhibit Y** (Linda Booker, TENNESSEE DEPARTMENT OF CORRECTION, DECISION SUPPORT: RESEARCH AND PLANNING, *Fiscal Year 2020 Statistical Abstract* (Oct. 2020)) at 69; **Exhibit Z (**Linda Booker, TENNESSEE DEPARTMENT OF CORRECTION, DECISION SUPPORT: RESEARCH AND PLANNING, *Fiscal Year 2021 Statistical Abstract* (Sep. 2021)) at 86; **Exhibit AA** (Linda Booker, TENNESSEE DEPARTMENT OF CORRECTION, DECISION SUPPORT: RESEARCH AND PLANNING, *Fiscal Year 2022 Statistical Abstract* (Sep. 2022)) at 89.

[78] **Ex. Y** at 21,69; **Ex. Z** at 22, 86.

[79] **Ex. V**.

[80] **Ex. X**.

[81] **Ex. Y** at 22, 86.

[82] **Ex. Z** at 23, 89.

[83] **Ex. V**.

[84] **Ex. X**.

[85] **Ex. Y** at 22, 86; **Ex. Z** at 23, 89.

158. The Jail reported 565 inmate-on-inmate assaults that year,[86] with an average Daily population of 2,035.[87]

159. The County continued to understaff the Jail, despite knowing the numbers above and the stories those numbers told.

160. Deflecting all semblance of accountability, Bonner refuses to acknowledge any problem exists in the Jail.[88]

G. *The County Government's Complicity*

161. Since the time of the DOJ litigation referenced above, the SCSO has provided the County Commissioners and the Shelby County Mayor with monthly "Jail Report Cards." These documents report the number of in-custody incidents (including inmate assaults and death), reflect staffing patterns, and—long before November 2022—put both the County Commission and the Mayor's office on notice of the disturbing trends the Jail Report Cards presented.

162. Despite having notice of the Jail's chronic understaffing and correlated increase in inmate assaults and death, the County Mayor's office has declined to intervene, propose any significant increase in funding for Jail personnel, or request the assistance of outside law-enforcement agencies.

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[86] **Ex. W**.

[87] **Ex. X**.

[88] Questioned about the sharp rise in Jail fatalities corresponding to his tenure as Sheriff, Bonner responded:

> As the COVID-19 pandemic, the influx of opioids/fentanyl, and the mental health crisis that caused increasing suicides came to Shelby County, deaths in the jail mirrored what was happening in the community.

Burgess, *supra.* This was nonsense, of course. Shelby County's total population experienced nothing like a threefold increase in deathrate.

163. The County Commission convened on February 7, 2022. This date fell between the Ragland assault (due to Jail understaffing and lack of inmate supervision) and the Davis death (also due to Jail understaffing and lack of inmate supervision) discussed above. Although there remained at least eighty-five vacant guard posts in the Jail, the County Commission considered and passed a resolution amending the FY 2022 County Budget to allocate approximately $2,900,000.00 from the SCSO Personnel Fund to its Operations and Maintenance Fund.[89]The legislative summary for the resolution indicates Bonner's strong approval.[90]

164. Plaintiffs aver, on specific information and belief, that Bonner requested the re-allocation of personnel funds in part to pay for new motorcycles from Bumpus Harley Davidson.[91]

165. The County saw continued increase in the number of inmate-on-inmate assaults in the Jail as the June 30, 2022 deadline for finalizing the County's FY 2022 budget approached. 222 inmate-on inmate assaults occurred in the first six months of the 2021 calendar year.[92] 271 occurred in the first six months of the 2022 calendar year.[93] Things were getting worse.

166. Despite all of the trends covered above and the fact those problems were actively getting worse, the County Commission final FY 2022 budget took away an additional twenty-two guard positions from the Jail.[94] This move saved no taxpayer money, because the total staff

[89] **Exhibit BB** at 1–2.

[90] *Id.* at 3.

[91] *See* **Exhibit CC**.

[92] **Exhibit DD**.

[93] *Id.*

[94] **Example EE** at 193.

compliment for SCSO did not change; funding for Jail guards just went to other divisions of the SCSO. Bonner's administrative staff received eighteen of the twenty-two transferred positions.[95]

167. The County Commission's FY 2022 budget passed with the full support and endorsement of both Bonner and the County Mayor's office. All County entities knew how bad the Jail numbers were, because they received monthly updates. They apparently did not care.

V.
FEDERAL CAUSES OF ACTION

168. Plaintiffs incorporate, reallege, and rely on the preceding allegations as if fully pleaded hereunder for each of the following counts.

A. *Count One:* Monell *Liability under 42 U.S.C. § 1983—Official Policy: Fatal Understaffing*

169. Bonner's alteration of the Jail's staffing patterns—to the extent the Jail eliminated guard postings in cell pods or changed the classification of these posts from "fixed" to either "pull" or "shutdown"—constituted an official policy of the County.

170. Bonner and Fields implemented and maintained (under)staffing patterns that eliminated guard postings within the cell pods, or changed the classification of these posts from "fixed" to either "pull" or "shutdown," with deliberate indifference to the constitutional rights of inmates at the Jail.

171. The (under)staffing patterns addressed under this Count were a moving force behind guards' absence from third floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

[95] *Id.*

172. The (under)staffing patterns addressed under this Count were a moving force behind guards' absence from third floor E-Pod during the prolonged period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

173. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of eliminating guard postings from inside the cell pods, or of changing the classification of these posts from "fixed" to either "pull" or "shutdown."

174. The elimination of guard postings from inside the cell pods, or the change of the classification of these posts from "fixed" to either "pull" or "shutdown," left Marcus Donald and his fellow E-Pod inmates utterly without protection, in violation of their Eighth Amendment rights.

175. As a direct and proximate result of the Jail (under)staffing patterns described under this Count, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

176. As a direct and proximate result of the Jail's (under)staffing patterns described under this Count, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

177. As a direct and proximate result of the Jail's (under)staffing patterns described under this Count, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

B. ***Count Two:*** **Monell** ***Liability 42 U.S.C. § 1983—Official Policy: Indirect Supervision***

178. Bonner's alteration of the Jail's staffing patterns—to the extent the Jail eliminated guard postings in the control room, or changed the classification of these posts from "fixed" to either "pull" or "shutdown"—constituted an official policy of the County.

179. Bonner and Fields implemented and maintained (under)staffing patterns that eliminated guard postings from the control room, or changed the classification these posts from "fixed" to either "pull" or "shutdown," with deliberate indifference to the constitutional rights of inmates at the Jail.

180. The (under)staffing patterns addressed under this Count were a moving force behind guards' absence from third floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

181. The (under)staffing patterns addressed under this Count were a moving force behind guards' absence from third floor E-Pod during the prolonged period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

182. The elimination of guard postings from inside the control room, or the change of the classification of these posts from "fixed" to either "pull" or "shutdown," left Marcus Donald and his fellow E-Pod inmates utterly without protection, in violation of their Eighth Amendment rights.

183. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of eliminating guard postings from inside the control room, or of changing the classification of these posts from "fixed" to either "pull" or "shutdown."

184. As a direct and proximate result of the Jail (under)staffing patterns described under this Count, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to

compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

185. As a direct and proximate result of the Jail's (under)staffing patterns described under this Count, Marcus Donald suffered brain damage and death.

186. As a direct and proximate result of the Jail's (under)staffing patterns described under this Count, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

C. *Count Three:* **Monell** *Liability under 42 U.S.C. § 1983—Official Policy: (Under)Staffing Procedures*

187. The SCSO's Standard Operating Procedures for Roster Management, which allows temporary staffing-pattern revisions based only on a certainty—rather than a likelihood—of inmate injury or death constituted an official policy of the County.

188. Bonner, Fields, and County leadership at large adhere to the Roster Management Policy, to the extent it allows temporary revisions based only on a certainty of inmate injury or death, with deliberate indifference to the constitutional rights of inmates at the Jail.

189. The requirement of certain inmate injury or death to revise staffing patterns was a moving force behind guards' absence from third floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

190. The requirement of certain inmate injury or death to revise staffing patterns was a moving force behind guards' absence from third-floor E-Pod during the prolonged period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

191. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of the Rooster Management Policy's exclusion of likely inmate injury or death as a basis for temporary staffing revisions.

192. As a direct and proximate result of the Jail's Roster Management Policy as described under this Count, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

193. As a direct and proximate result of the Jail's Roster Management Policy as described under this Count, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

194. As a direct and proximate result of the Jail's Roster Management Policy as described under this Count, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

D. *Count Four*: Monell *liability under 42 U.S.C. § 1983—Official Policy: (Under)Staffing and Lack of Supervision*

195. The Jail's Roster Management Policy—by its own terms and therefore as an official County Policy—ignores the most important measure of the staffing in the Jail: total staffing deficits per shift.

196. In failing to revise the clearly ineffective post-specific policy, these men and other County leaders acted with deliberate indifference to the constitutional rights of inmates at the Jail.

197. The Roster Management Policy's narrow, post-specific focus was a moving force behind guards' absence from 3rd Floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

198. The Roster Management Policy's narrow, post-specific focus was a moving force behind guards' absence from 3rd Floor E-Pod during the period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

199. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of Bonner, Fields, and the County leadership's nonsensical post-specific staffing policy.

200. As a direct and proximate result of the Roster Management Policy's narrow, post-specific staffing policy, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

201. As a direct and proximate result of the County's nonsensical narrow, post-specific staffing policy, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

202. As a direct and proximate result of the County's narrow, post-specific staffing policy, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

E. *Count Five:* **Monell** *Liability under 42 U.S.C. § 1983—Custom of Tolerance: Fatal Understaffing*

203. Bonner, Fields, and County leadership at large maintained a custom of tolerance for the Jail's gross understaffing by continuing to house largely unsupervised inmates without increasing the number of guards or the level of inmate monitoring and supervision.

204. The County's tolerance of dangerously low staffing levels at the Jail was so accepted, permanent, and well-settled as to take on and carry with it the force of law.

205. Bonner, Fields, and County leadership at large were consciously aware and on notice that their tolerance for the dangerously low staffing levels at the Jail was failing to protect the Jail population from the most violent persons among them and would encourage more inmate-on-inmate violence.

206. Bonner, Fields, and County leadership at large were consciously aware and on notice that their tolerance for the dangerously low staffing levels at the Jail was failing to protect the Jail population from a host of hazards by leaving guards unaware of life-threatening injuries when these occurred, unable to respond to such injuries promptly, or both.

207. Despite this conscious awareness, Bonner, Fields, and County leadership at large continued to tolerate the Jail's gross understaffing with deliberate indifference to, and at the expense of, the Jail population.

208. The County's open tolerance of the Jail's dangerously low staffing levels was a moving force behind guards' absence from third floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

209. The County's open tolerance of the Jail's dangerously low staffing levels was a moving force behind guards' absence from third floor E-Pod during the prolonged period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

210. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of Bonner, Fields, and County leadership's open tolerance of the Jail's dangerously low staffing levels.

211. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

212. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

213. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

F. *Count Six:* Monell *Liability under 42 U.S.C. § 1983—Custom of Tolerance: Failure to Release*

214. Bonner, Fields, and County leadership at large maintained a custom of tolerance for the Jail's conspicuous, ongoing failure to release or timely process out release-eligible inmates; they overlooked, downplayed, and refused to take even the slightest measures to remedy this problem.

215. The County's open tolerance for the Jail's holding persons in custody for ten-plus hours after their release eligibility was so accepted, permanent, and well-settled as to take on and carry with it the force of law.

216. Bonner, Fields, and County leadership at large were consciously aware and on notice that keeping release-eligible inmates violated these persons' rights under the Eight and Fourteenth Amendments.

217. Bonner, Fields, and County leadership at large were consciously aware and on notice that their Jail was a dangerous place, and the failure to timely release inmates was subjecting these persons to a constitutionally unjustifiable risk of death or serious bodily injury.

218. Despite this conscious awareness, Bonner, Fields, and County leadership at large continued to tolerate the Jail's slow-release practice with deliberate indifference to, and at the expense of, members the Jail population.

219. The County's open tolerance of the Jail's (under)staffing patterns that eliminated guard postings within the cell pods, coupled with the Jail's holding release-eligible inmates far beyond administratively acceptable timeframes, was a moving force behind guards' absence from third floor E-Pod during the two minutes it took Stephen Robinson to strangle Marcus Donald.

220. The County's open tolerance of the Jail's (under)staffing patterns was a moving force behind guards' absence from third floor E-Pod during the prolonged period of time after the strangulation when Marcus Donald lay helpless, not breathing, and unconscious at his killer's feet.

221. The County's Jail's slow-release practice was a moving force behind Marcus Donald's injuries and death, because it was the only reason he remained in custody roughly twelve or more hours after he was eligible to be processed out of custody.

222. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of Bonner, Fields, and County leadership's open tolerance of the culture of tolerance discussed under this count.

223. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

224. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

225. As a direct and proximate result of the culture of tolerance discussed under this Count, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

G. *Count Seven: Supervisory Liability under 42 U.S.C. § 1983—Bonner*

226. The Jail's dangerously low staffing levels encouraged and precipitated inmate-on-inmate violence, posing a substantial risk of serious bodily harm to members of the Jail population.

227. Sheriff Bonner had constructive notice of the Jail's dangerously low staffing levels, by virtue of the statutory charges and duties of his office, long before November 2022.

228. Sheriff Bonner had constructive notice that the Jail's dangerously low staffing levels were encouraging inmate-on-inmate violence, by virtue of the statutory charges and duties of his office, long before November 2022.

229. Sheriff Bonner's public statements prove he had actual, subjective notice of the Jail's dangerously low staffing levels long before November 2022.

230. Sheriff Bonner's public statements prove he had actual, subjective notice that the Jail's dangerously low staffing levels were encouraging inmate-on-inmate violence long before November 2022.

231. Sheriff Bonner failed to reasonably respond to—including failing to implement or approve any meaningful staffing changes in the face of—the substantial risk to inmate safety that the Jail's gross understaffing posed.

232. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of Sheriff Bonner's individual failure to reasonably respond to—including failing to implement or approve any meaningful staffing changes in the face of—the substantial risk to inmate safety that the Jail's gross understaffing posed.

233. As a direct and proximate result of Sheriff Bonner's individual failure to reasonably respond to—including failing to implement or approve any meaningful staffing changes in the face of—the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

234. As a direct and proximate result of Sheriff Bonner's individual failure to reasonably respond to—including failing to implement or approve any meaningful staffing changes in the face of—the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

235. As a direct and proximate result of Sheriff Bonner's individual failure to reasonably respond to—including failing to implement or approve any meaningful staffing changes in the face of—the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

H. *Count Eight: Supervisory Liability under 42. U.S.C. § 1983—Fields*

236. The Jail's dangerously low staffing levels encouraged and precipitated inmate-on-inmate violence, posing a substantial risk of serious bodily harm to members of the Jail population

237. Jailer Fields had constructive notice of the Jail's dangerously low staffing levels, by virtue of the statutory charges and duties of his office, long before November 2022.

238. Jailer Fields had constructive notice that the Jail's dangerously low staffing levels were encouraging inmate-on-inmate violence, by virtue of the statutory charges and duties of his office, long before November 2022.

239. Jailer Fields' public statements prove he had actual, subjective notice of the Jail's dangerously low staffing levels long before November 2022.

240. Jailer Fields' public statements prove he had actual, subjective notice that the Jail's dangerously low staffing levels were encouraging inmate-on-inmate violence long before November 2022.

241. Jailer Fields failed to reasonably respond to—or indeed, take any discernable action whatsoever in the face of—the risk that the gross understaffing of the Jail posed.

242. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of Jailer Fields' individual failure to take any reasonable action in the face of the substantial risk to inmate safety that the Jail's gross understaffing posed.

243. As a direct and proximate result of Jailer Fields' individual failure to take any action in the face of the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

244. As a direct and proximate result of Jailer Fields' individual failure to take any reasonable action in the face of the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald suffered catastrophic pain, anguish, terror, emotional distress, brain damage, and death.

245. As a direct and proximate result of Jailer Fields' individual failure to take any action in the face of the substantial risk to inmate safety that the Jail's gross understaffing posed, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

I. *Count Nine: Individual Liability under 42 U.S.C. § 1983—Lieutenant Parker*

246. At all relevant times, Lieutenant Parker was acting under color of state law.

247. As alleged above, Lieutenant Parker's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

248. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

J. *Count Ten: Individual Liability under 42 U.S.C. § 1983—Lieutenant Varner*

249. At all relevant times, Lieutenant Varner was acting under color of state law.

250. As alleged above, Lieutenant Varner's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

251. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

K. *Count Eleven:Individual Liability under 42 U.S.C. § 1983—Sergeant Williams*

252. At all relevant times, Sergeant Williams was acting under color of state law.

253. As alleged above, Sergeant Williams' conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

254. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

L. *Count Twelve: Individual Liability under 42 U.S.C. § 1983—Sergeant Johnson*

255. At all relevant times, Sergeant Johnson was acting under color of state law.

256. As alleged above, Sergeant Johnson's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

257. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

M. *Count Thirteen: Individual Liability under 42 U.S.C. § 1983—DRT Robertson*

258. At all relevant times, DRT Robertson was acting under color of state law.

259. As alleged above, DRT Robertson's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

260. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

N. *Count Fourteen: Individual Liability under 42 U.S.C. § 1983—DRT Smith*

261. At all relevant times, DRT Smith was acting under color of state law.

262. As alleged above, DRT Smith's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

263. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

O. *Count Fifteen: Individual Liability under 42 U.S.C. § 1983—DRT Baker*

264. At all relevant times, DRT Baker was acting under color of state law.

265. As alleged above, DRT Baker's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

266. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

P. *Count Sixteen: Individual Liability under 42 U.S.C. § 1983—D. Hawkins*

267. At all relevant times, D. Hawkins was acting under color of state law.

268. As alleged above, Hawkins' conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

269. These violations caused Marcus Donald and Plaintiffs grievous injury and death

Q. *Count Seventeen: Individual Liability under 42 U.S.C. § 1983—K. Wallace*

270. At all relevant times, K. Wallace was acting under color of state law

271. As alleged above, Wallace's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

272. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

R. *Count Eighteen: Individual Liability under 42 U.S.C. § 1983—McCoy*

273. At all relevant times, McCoy was acting under color of state law.

274. As alleged above, McCoy's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

275. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

S. *Count Nineteen: Individual Liability under 42 U.S.C. § 1983—Grandberry*

276. At all relevant times, Grandberry was acting under color of state law.

277. As alleged above, Grandberry's conduct deprived Marcus Donald of certain rights under the Eighth and Fourteenth Amendments to the United States Constitution.

278. These violations caused Marcus Donald and Plaintiffs grievous injury and death.

VI.
PENDANT CAUSES OF ACTION

279. Plaintiffs incorporate, reallege, and rely on the preceding allegations as if fully pleaded hereunder for each of the following counts.

A. *Count Ten: Jail Employees' Negligence*

280. The Jail guards who entered third floor E-Pod at 12:23 AM on November 18, 2022 (the "Responding Guards") were County employees.

281. The Responding Guards had a common-law duty to render reasonable medical care to Marcus Donald when they discovered him unconscious on the floor of E-Pod cell 10.

282. The responding Guards breached their duty to render reasonable medical care to Marcus Donald by waiting at least five minutes before attempting cardio-pulmonary resuscitation ("CPR") on him, although they knew Marcus Donald was unconscious and not breathing.

283. Marcus Donald's injuries and death were a foreseeable, legal, and proximate result of the Responding Guards' unjustified delay in beginning CPR.

284. As a direct and proximate result of the Responding Guards' unjustified delay in beginning CPR, Marcus Donald and Plaintiffs suffered grievous injury, entitling Plaintiffs to compensatory and special damages, as defined under federal common law, in an amount to be determined by a jury.

285. As a direct and proximate result of the Responding Guards' unjustified delay in beginning CPR, Marcus Donald suffered brain damage and death.

286. As a direct and proximate result of the Responding Guards' unjustified delay in beginning CPR, Marcus Donald's wrongful-death beneficiaries suffered pecuniary loss, including medical, travel, and funeral expenses; loss of future wages and earnings; loss of companionship and consortium; and loss of the costs of prosecuting this action, including their attorneys' fees.

VII.
PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully demand the following relief as of right:

A. That process issue and Defendants, having waived service of process or been duly served, be required to answer or otherwise respond to this Complaint in the time and manner provided by law;

B. That a jury of eight or more persons be empaneled to hear and decide all jury-triable issues raised above or as may subsequently arise during the action or emerge from discovery;

C. That, upon a verdict, Judgement be entered in Plaintiffs' favor, over and against Defendants, for which execution may issue;

D. That such judgment award damages in an amount to be determined according to the proof, but in no event less than SEVENTY-FIVE MILLION and no/100 DOLLARS ($75,000,000.00);

E. That, in addition to damages awarded, Plaintiffs be awarded all costs incurred in prosecuting this action, including reasonable attorneys' fees under 42 U.S.C. § 1988; and

F. For such other and further relief as may be appropriate under the circumstances.

Dated November 17, 2023.

Respectfully submitted,

/s/ Sara Katherine McKinney
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